INSTRUCTIONS FOR FILLING OUT ENROLLMENT APPLICATION

SECTION I - TO BE COMPLETED BY ALL PROVIDERS:

Name of owner - Legal owner(s) of business.
Effective Date - List the date, which you would like your provider number to be effective. In the case of a change of IRS number only, these will not be made retroactive.
Business name - List name that you will be doing business under. This is the name that all payments will be made to.
Business phone - List the phone number where normal business practices take place. Do not list phone number of billing agents.
Business Fax - List any additional phone number that is used as a fax line.
Physical Business Address - List the address where the business is physically located.
Mailing Address - List the mailing address where you want to have correspondence and checks sent to if other than the physical address.
Type of practice - List the type of service that you provide. For example, medical, ambulance, dental etc.
Specialty - List your specialty within your practice.
NCPDP number - Pharmacies only. List the NCPDP (National Council for Prescription Drug Programs) number for your pharmacy. This was formerly your NABP number.
IRS number - List the IRS number under which this provider number will be paid. This is also referred to as your Taxpayer Identification Number (TIN).
Professional license no. - For providers that are professionally licensed to perform services, this is the license number on your license. **A copy of the license, showing the issue and expiration date, for each licensed professional, must accompany the enrollment application.**
State - The state in which you are licensed to perform services.
Medicare provider number - List the provider number under which you bill Medicare.
NPI - Possible HIPAA requirement. Not required at this time.
Social Security number - This is the SSN that payment will be made under if there is not an IRS number listed.
Signature of Authorized Agent - for individual practitioners, this must be the signature of the individual practitioner. In the case of a group setting, this is the signature of the clinic manager or an owner.

SECTION II - TO BE COMPLETED BY ALL PROVIDERS PRACTICING UNDER THIS AGREEMENT. IN THE CASE OF AN INDIVIDUAL PRACTICE, THIS MUST STILL BE COMPLETED FOR THE INDIVIDUAL IN ADDITION TO SECTION I. ALL PROVIDERS IN GROUP MUST FILL OUT SECTION II. ADDITIONAL SPACES ARE PROVIDED ON PAGE 4 OF APPLICATION.

Name: This is the name of the individual practicing under this number.
Professional Lic. No. - For providers that are professionally licensed to perform services, this is the license number on your license. **A copy of the license, showing the issue and expiration date, for each licensed professional, must accompany the enrollment application.**
State: This is the state which issued your professional license.
Medicare Prov. No. - This is the individual provider number which you bill Medicare under as a performing provider.
NPI - Possible HIPAA requirement. Not required at this time.
Type of Practice -List the type of service that you provide. For example, medical, ambulance, dental etc.
Specialty - List your specialty within your practice.
Subspecialty - List your subspecialty within your practice if you have one.
Social Security number - List your social security number.
DEA (narcotic) No. - List your DEA number if you have one.
Medicaid Provider No. - If you already have a Medicaid provider number, please list it here.
Gender - Please indicate your gender.
Date of Birth - Please indicate date of birth.
Signature - this must be the signature of the individual practitioner in section II.

SECTION III - TO BE COMPLETED BY ALL PROVIDERS

1. Has any provider of service included on this agreement ever been convicted of a felony? - If you answer "yes" please include the date of the conviction, the charges and the final disposition of those charges.
2. Has any provider of service included on this agreement ever been denied malpractice insurance? - If you answer "yes" please include the date of denial and the date your insurance was reinstated.
3. Does any provider of service included on this agreement had any restrictions placed upon his/her license? - If you answer "yes", please include the dates and specifics of the restrictions.

OWNERSHIP DISCLOSURE -

1. You must disclose the name and address of every person with an ownership or control interest in the disclosing entity (Section I of Enrollment Application) or in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5 percent of more.

2. You must also disclose if any of the owners listed in #1 are related to one another. If so, please list the owner's names and their relationship to one another.

3. You must also disclose if any of the owners listed in #1 also have ownership or controlling interest in other entities. If so, please list which persons and the names and addresses of the other entities.